Continuity of Care Workgroup Notes 9/20

CRISP Review

- Statewide HIE – opt out model
- Date is flowing through HIE unless you have opted out
- Right now you can't opt out at point of service, you have to send letter or fill out a form.
- Connect orgs are hospitals (all are queryable) very few ambulatory providers, some primary care doctors (larger practices mostly)
- Not behavioral health providers with data queryable through CRISP – concern over extra protections for mental health and substance abuse records
- AG opinion 2007 addressing whether mental health records should even be searchable through CRISP – understanding is that its OK for mental health records to flow through HIE but the gray area is that the state protection actually says mental health records part that are available is that which is specifically needed to answer the question – have to specify exactly what you need
    - CRISP and other functions aren't savvy enough to parse that info and send bits and pieces – now you query all or none of record
    - Lot of discussion about leaving mental health records
    - Need to try to figure out how to use this and still protect information
- Way Station has signed on for CRISP – was under impression can't put mental health records into portal
    - One modification/improvement – can we get auto push from CRISP to hospital, even if not sharing behavioral health info can at least ID if a provider is involved
    - Need to be careful – lamenting that cant have more behavioral health info shared so people know how to better care for people v. privacy rates
- Added layer of protection in state and federal law for sharing record – but no one is touching substance abuse records right now
- CRISP is – PCPs are finding out or being notified through CRISP if they have a patient that goes into the hospital
- Is there a way for patients to choose to have that information included in CRISP? Some want all info available to hospitals – but impression is that can't share it
    - **What constitutes consent and how much information can we share? Can we push info to hospital that provider is involved? Clarification on services**
- In original policies & procedures it was suggested was that people should be able to choose yes include all/part/no data – but when draft regs came out they decided this wasn't a doable thing at this time
- What is sensitive info? Mental health, domestic violence, HIV, etc
- Don't let technology drive regulations…but it gets taken into consideration
- **Action item: clarity on what does minimum necessary mean in the real world? There seem to be different opinions and AG opinion didn't clarify that.**
- Consent issues –
- Educate mental health care workers so that they know they can listen to people even if they can't share information with the family member/person. Workers are saying they cant talk because there isn't a permission slip. Ties in with education on sharing information when providing care – listening to families is not a violation of HIPAA
    - Not just hospitals, but also in the criminal justice system
    - **Only have CRISP record if you've been in a general hospital, it doesn't include criminal justice system etc**

Clinical Review Panels/Forced medication

- Consider: Having one hearing for medication and commitment can shorten time in hospital

- Its taking too long to get medications – prolonging is health issue – is there a way to shorten the timeline especially where there is already information and history – is there another way to help
    - Least restrictive alternative issue
- Challenge with Kelly case is that when you talk about least restrictive alternative; when in
    - First involuntary commitment, separate hearing later, its two different restrictions – people end up being confined for longer periods of time waiting for treatment – in the end is that really less restrictive?
    - When people know there is an order they can negotiate, don't want to force meds if don't have to but it that adds pressure to take meds so people can leave the hospital
    - Challenge for families and doctors, what can they do if they aren't accepting treatment but are being confined in the hospital?
    - Issue people have constitutional right to refuse medication if they are competent, only interest of state can overcome that right
        - Legal analysis as to when state can override those rights (issue of standard – danger to self)
        - Interest in bodily integrity as second interest
    - Issue with jumping the gun with commitment and medication at same time
    - Any change in statute to say standard not dangerous in facility would be subject to legal challenge
- What about being moved around hospitals because of insurance – this is appealable decision – medical necessity is appealable
- Different standards for civil commitment v forced medication
- AG psychiatric advance directives – if a patient has that can clinicians don't want to force patients to take meds by going to ALJ, but would like to use directives as part of that directive, but issue is once they've lost capacity the advanced directive go away? Its useless if they use capacity – can these be used to forgo a clinical review panel?
    - Another education problem with the process
- **Prohibitive costs to go through guardianship process + time delay – is there a way to fix this process – families need more support and education to go through the process – clarification or help from legal aid would be appropriate**
- Ulysses clause; delay in revoking advance directive
- If there is a constitutional issue with Kelly that seems to be more restrictive than other states why hasn't it been addressed in other states
- Conflict in some of the guardian statutes – maybe if someone has a guardian, 10-632 could be changed to allow preliminary hearing with ALJ to see if someone is competent to sign continuous assent to stay in hospital.
    - Change health-gen and & guardianship statute (702?)
    - Conflict b/c someone can only be admitted to hospital under civil commitment; but another says they don't lose civil rights by guardianship
    - Only so many hospitals take civilly committed patients (three DON'T - bayview, Montgomery general, st joe) suburban?
- Statutes in other states that allow guardians to admit people ot the hospital. Can guardian give consent to forced medication? They can consent to psycotropic if its in the guardianship
    - First you have to get over hurdle of admitted to hospital
    - Pros and cons of advance directive v. guardianship?
        - Website – AG and advance directive
- Desire: family/next of kin/person who did petition to be notified of hearing process; and should be able to stay in the hearing (in MD can only be while testifying)
    - But this is a HIPAA violation if the patient hasn't agreed to be told – back to confidentiality
    - Can be notified about civil commitment hearing only
    - Can't be in whole time because of due process

- Special carve out for news circumstances – some opportunity for revisit of decisions to not treat medication after some period of time after its been demonstrated that its not been effective (competent, doesn't meet danger criteria, but he is still confined)
    - If standard is dangerous in facility, that sort of defeats the point – they will be non-dangerous when confined but not in community – this is an issue
- **Want clarification: can a family member attend med panel hearing?**
    - Ways for family members to stay involved – they can contribute with substantial information
    - More of medical review of anti-psychotic before they are changed so there is more consistency from meds
- Clarification and education for consumers, family, providers because of inconsistency between facilities
- Danger of slippery slope if you stop listening to patients that have been deemed competent
- Issue of competence then danger – competency can take longer and danger could be immediate – suggest to define it more broadly & clarify it and that it should be considered out of the hospital not just in the hospital b/c goal is to not keep patient in hospital forever
- Standard of competency not at ALJ level (???) over burden of guardianship
- Suggestion that Kelly law as barrier to care and wants it reversed
- Inconsistency in how things are applied – CEUs required in ERs for mental health education – legislate this
    - Education on process for not applying it correctly and how to fix it, and how to get more hands on training for ones that aren't – need monitoring and grievance process as well

Other Issues:

- Mental health courts – should it be expanded in MD? There is a judiciary subcommittee looking at this
- What about mandating training for Judges?
- Maryland doesn't mandate case management for SMI population is a barrier to care and coordination
- Need for treatment vs. dangerous standard (welfare of patient over danger to self)